S. No. 300
y. 10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12191

FILED APR 4 1953

BIRTH NO. 25853 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3227

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Louis Maternity

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis 2119
d. STREET ADDRESS (If rural, give location) 3959 Cottage Avenue

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Rainey

4. DATE OF DEATH (Month) (Day) (Year) March 14 1953

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	-	March 13 1953				19	30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY?
--	--	St Louis Missouri	

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Warren Clayton Rainey	Juanita Lucille Trout	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
-	-	-	Warren & Juanita Rainey	3959 Cottage Ave

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intracranial Hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Anoxia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe atelectasis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		7600

22. *I hereby certify that I attended the deceased from* March 13, 1953, *to* March 14, 19 53 *that I last saw the deceased alive on* March 14, 19 53 *and that death occurred at* 6:45 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Miriam M. Pennoyer MD	630 S. Kingshighway	3-17-53

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
	3-3/-53	Anatomical Board	St. Louis, Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
MAR 26 1953	J Carl Smith MD	Rowland	4104 Manchester

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.